EXHIBIT A

Public Health Emergency Preparedness Work Plan
For
Local Health Departments
PPCPS/HAZARDS

Funding Opportunity Number CDC-RFA-TP12-1201

Introduction

DSHS developed this work plan in support of the Public Health Emergency Preparedness Cooperative Agreement (Funding Opportunity Number CDC-RFA-TP12-1201) from the Centers for Disease Control and Prevention (CDC). The funding opportunity announcement addresses alignment of the Public Health Emergency Preparedness (PHEP) Program and the Hospital Preparedness Program (HPP) through a five-year project period from 2012 to 2017,as noted in Section I. Statement of Work of the Program Attachment.

DSHS also developed this work plan in the spirit of flexibility and continuous quality improvement providing local health departments the ability to accomplish the intent of the PHEP HPP Cooperative Agreement with as much latitude as possible while adhering to the guidance of the funding opportunity announcement.

The work plan consists of the following sections that describe the activities and deliverables for PHEP 2011 to 2012, Budget Period 11 (August 1, 2011 to July 31, 2012):

I. Public Health Preparedness Capabilities
II. Annual Requirements
III. CDC-Defined Performance Measures
IV. Evidence-based Benchmarks and Pandemic Influenza Plans (PAHPA Benchmarks)

I. Public Health Preparedness Capabilities

Public health departments continue to face multiple challenges, including an ever-evolving list of public health threats. The Centers for Disease Control and Prevention (CDC) developed fifteen (15) capabilities to assist health departments with assessing preparedness capacity as well as developing strategic plans. The CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* is a published document found at the following link:
http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf.

The activities associated with this work plan link directly to the standardized capabilities briefly outlined in Section I. Statement of Work of the Program Attachment and found in full detail in the PDF document referenced above.

During this project period, Texas Department of State Health Services (DSHS) with consultation from the CDC intends to foster closer alignment between the PHEP Program and Hospital Preparedness Program. Grant alignment is a long-term initiative that will continue to evolve throughout the project period as PHEP and HPP seek additional opportunities to improve administrative and programmatic collaboration. DSHS recognizes that the capabilities required to fulfill HPP and PHEP programmatic goals differ but that increased collaboration will serve to strengthen both programs.

In 2011, CDC released a Public Health Capabilities Planning Model that describes a high-level planning process public health departments may wish to follow as they address the 15 public health capabilities. The planning model allows local health departments to use the public health preparedness capabilities to a) determine preparedness priorities, b) plan appropriate preparedness activities, and c) demonstrate and evaluate achievement of capabilities through exercises, planned events, and real incidents. Contractors are encouraged to use routine activities and real incidents to demonstrate and evaluate the public health preparedness capabilities.

DSHS with consultation from the CDC strongly recommends that local health departments utilize a prioritization strategy to determine their work and the resulting investments regarding the 15 public health preparedness capabilities across the five-year project period based upon:

1) Jurisdictional risk assessments (reference the capability standards document for details on the Community Preparedness Capability 1 and requirements for risk assessments);

2) Current capabilities assessments and gap analyses identified using CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning* as well as a self-assessment process utilizing CDC's Capabilities Planning Guide (CPG); and

3) CDC's recommended tiered strategy for capabilities outlined below

Tier 1 Public Health Preparedness Capabilities:

- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Community Preparedness
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Responder Safety and Health
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Information Sharing

Tier 2 Public Health Preparedness Capabilities:

- Non-Pharmaceutical Intervention
- Medical Surge*
- Volunteer Management*
- Community Recovery
- Fatality Management*
- Mass Care

*PHEP funding should support the development of these Tier 2 capabilities in coordination with HPP activities.

Activity 1 for Section I, PHEP Capabilities: Continue to Conduct Jurisdictional Risk Assessments

Local health department personnel, DSHS health service regional staff, and DSHS central office staff developed the Texas Public Health Risk Assessment Tool (TPHRAT) during budget period 2011 to 2012 for use by local health departments in Texas to conduct jurisdictional risk assessments. The tool incorporates a capability-based approach and includes the identification of potential hazards, vulnerabilities, and risks within communities that relate to the public health, medical, and mental/behavioral health systems inclusive of at-risk individuals (See Public Health Preparedness Capability 1 of the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* document.)

Jurisdictional risk assessments should be developed in coordination with hospital preparedness partners, emergency management, and other community partners. The Threat Hazard Identification Risk Assessment (THIRA) from the Department of Homeland Security is a reference document for conducting jurisdictional risk assessments. The document is located at the following link:

http://www.dhs.gov/xlibrary/assets/rma-strategic-national-risk-assessment-ppd8.pdf

Deliverable 1 for Activity 1 for Section I, PHEP Capabilities

Status reports on the risk assessments using a template provided by DSHS must be submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC.

Deliverable 2 for Activity 1 for Section 1, PHEP Capabilities

Local jurisdictional risk assessments using the TPHRAT or data from the TPHRAT sufficient to meet the requirement from CDC for a state-level, awardee jurisdictional risk assessment must be submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC.

Activity 2 for Section 1, PHEP Capabilities: Continue to Perform Capability Assessments

CDC developed the Capabilities Planning Guide as a tool for local health departments to utilize in performing capabilities assessments. The document is located at the following link:

http://www.dshs.state.tx.us/commprep/phep/PHEP_CPG.aspx

Data analyses from the files associated with the link will result in a report from CDC intended to assist local health departments in prioritizing levels of action to address functions within capabilities. The levels of actions are:

1. no action necessary (no recommendation)
2. sustain
3. address as low priority
4. address as medium priority
5. address as high priority
6. address as very high priority

Deliverable 1 for Activity 2 for Section 1, PHEP Capabilities

Capabilities Planning Guide files must be submitted to submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC. Capabilities Planning Guide files must be submitted to DSHS via the following email address: phep@dshs.state.tx.us

Activity 3 for Section 1, PHEP Capabilities: Utilize CDC's Recommended Tiered Strategy as a Planning Component for the Health Department's Capability Prioritization

CDC's tiered strategy emphasizes Tier 1 capabilities because these capabilities provide the foundation for public health emergency preparedness. PHEP recipients should build priority resource elements in Tier I capabilities prior to comprehensive or significant investment in Tier 2 public health emergency preparedness capabilities.

Deliverable 1 for Activity 3 for Section 1, PHEP Capabilities (dependent on possible CDC request during the budget period)

Status reports on utilizing the tiered strategy using a template provided by DSHS must be submitted to DSHS within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC should CDC require reporting of such utilization.

II. Annual Requirements

Contractors are required to submit plans, status reports, and program and financial data, outlining progress in addressing annual requirements including evidence-based benchmarks and objective standards and performance data. Reports will also include information on outcomes of annual preparedness exercises regarding strengths, weaknesses and associated corrective actions, accomplishments highlighting the impact and value of the PHEP program in local jurisdictions; and descriptions of incidents requiring activations of emergency operations centers. Reports must describe the preparedness activities that were conducted with PHEP funds, the purposes for which PHEP funds were spent and the recipients of the funds; describe the extent to which the Contractor has met stated goals and objectives. To assist Contractors, DSHS will provide

a template consistent with information required by CDC to meet the following annual planning/reporting requirements for 2012 to 2013. .

1) HPP and PHEP Program Alignment
   Contractors must demonstrate progress in coordinating public health and healthcare preparedness program activities and leveraging funding to support those activities as well as tracking accomplishments highlighting the impact of the HPP and PHEP programs in contractors' jurisdictions.

2) Administrative Preparedness Strategies (Capability 1. Community Preparedness): Contractors must describe administrative processes and approaches to receive and use emergency funds to mitigate and respond to emergency situations in a timely manner and actions to overcome challenges and barriers. Capability 1: Community Preparedness.

3) Exercise Planning and Implementation
   Contractors must revise current multi-year exercise plans or develop a new plan for conducting exercises to test public health and healthcare preparedness capabilities. As part of this process, contractors must conduct one joint, full-scale exercise within the five-year project period. Joint exercises should meet multiple program requirements including PHEP, HPP, and Strategic National Stockpile requirements to minimize the burden on exercise planners and participants. Exercise plans must demonstrate coordination with relevant entities and include methods to leverage resources to the maximum extent possible. Exercise plans must be submitted to DSHS annually. Plans must include exercise schedules and describe exercise goals and objectives, identified capabilities to be tested, inclusion of at-risk individuals, participating partner organizations, and previously identified improvement plan items from real incidents or previous exercises. The multi-year plan must be updated annually.

4) Healthcare Coalition Planning
   Contractors must contribute to successful coordinated preparedness. To do so, a plan must be developed to coordinate preparedness efforts among healthcare, public health, and behavioral health at the healthcare coalition level. This plan must include the strategy used by public health, healthcare, and mental health partners to encourage coordinated preparedness with preparedness partners at the jurisdictional level. The plan must also include a strategy to achieve mutual understandings among emergency response disciplines regarding respective roles in public health emergency preparedness and response. Plans must be submitted by to DSHS on a template provided by DSHS and within an established timeframe designated by DSHS in order to complete consolidation of statewide reporting to CDC.

5) Volunteer Recruitment and Management (Capability 15, Volunteer Management): Contractor shall document efforts for volunteer recruitment and

management such as development of a Medical Reserve Corps or community equivalent and use of the Texas Disaster Volunteer Registry.

6) Coordination among cross-cutting public health preparedness programs
PHEP program components as a whole should complement and be coordinated with other public health and healthcare programs as applicable. For example, some functions within the Public Health Laboratory, Public Health Surveillance and Epidemiological Investigation and Information Sharing capabilities may mutually support activities as described in CDC's Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement. Contractors should work with immunization programs and partners on syndromic surveillance and other activities to assure preparedness for vaccine-preventable diseases, influenza pandemics, and other events requiring a response.

7) Stakeholder Engagement (Capability 1, Community Preparedness Function 2 and Capability 2, Community Recovery, Function 1): Contractors shall identify the appropriate jurisdictional partner to address the emergency preparedness, response, and recovery needs of the older adults regarding public health, medical and mental health behavioral needs and address processes and accomplishments to meet these needs.

8) Public Comment Solicitation on Emergency Preparedness Plans (Capability 1, Community Preparedness, Function 2): Contractor shall describe processes for solicitation of public comment on emergency preparedness plans and their implementation such as the establishment of an advisory committee or similar mechanism to ensure ongoing public comment on emergency preparedness and response plans.

9) National Incident Management System (NIMS) (Capability 3, Emergency Operations Centers, Function 1):
Contractors should have plans, processes, and training in place to meet NIMS compliance requirements.

10) Public Health, Mental/Behavioral Health, and Medical Needs of At-risk Individuals (Capability 1, Community Preparedness; Capability 2, Community Recovery; Capability 4, Emergency Public Information and Warning; Capability 7, Mass Care; Capability 10, Medical Surge; and Capability 13, Public Health Surveillance and Epidemiological Investigation).

    Describe plans to address the public health, mental/behavioral health, and medical needs of at-risk individuals in the event of a public health emergency. The definition of at-risk individuals is available at: http://www.phe.gov/Preparedness/planning/abc/Documents/at-risk-individuals.pdf

11) Situational Awareness

Contactors will provide DSHS with situational awareness data generated through interoperable networks of electronic data systems. (Capability 6, Information Sharing)

12) Fiscal and Programmatic Systems Contractors will have in place fiscal and programmatic systems to document accountability and improvement.

13) One Annual Preparedness Exercise
Contractors will conduct at least one (1) preparedness exercise annually according to the Contractor's exercise plan and developed in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) standards. Contractor will submit to DSHS an exercise notification as soon as possible prior to the exercise and a final After Action Review/Improvement Plan within 60 days of the exercise.
The exercise can include a tabletop exercise, a drill, a functional exercise, or a full-scale exercise to test preparedness and response capabilities. Following such exercises, Contractors will report identified strengths, weaknesses, and corrective actions taken to address material weaknesses. CDC encourages PHEP recipients to exercise all preparedness capabilities; however, annual drills conducted to meet CDC's medical countermeasures dispensing and distribution (MCMDD) composite score can satisfy this requirement.

Activities for Section II, Annual Requirements

Local health departments have the flexibility to determine jurisdiction-specific activities for annual requirements.

Deliverables for Section II, Annual Requirements 1 and 2 and 4 through 12

Progress reports, program data, plans, and financial data from local health departments are deliverables for annual requirements 1 through 12. DSHS will provide templates for reports that are consistent with information requests from CDC in order to meet reporting requirements within a timeframe necessary to complete consolidation of statewide reporting to CDC.

Deliverable 1 for Section II, Annual Requirement 3
(Exercise Planning and Implementation)

Contractors must revise a current exercise plan or develop a new one and submit the plan to DSHS during Budget Period1 by a date to be determined following input from local health departments.

Deliverable 1 for Section II, Annual Requirement 13
(One Annual Preparedness Exercise)

Submit an exercise notification to DSHS as soon as possible during the planning process for the exercise.

Deliverable 2 for Section II, Annual Requirement 13
(One Annual Preparedness Exercise)

Submit an HSEEP-compliant After Action Review/Improvement Plan to DSHS within 60 days of the exercise.

III. CDC-Defined Performance Measures

Performance measures are key tools to determine program effectiveness and may focus on any level of public health service delivery including local health departments, public health laboratories, healthcare coalitions, and healthcare organizations. DSHS with consultation from the CDC has determined the benefit of Contractors reporting on these capability-based performance measures. While Contractors will not have to report on all performance measures every year, Contractors will be required to collect and report select performance measure data for Budget Period 1 (2012 to 2013) on the following public health preparedness capabilities:

Community Preparedness, Capability 1
Emergency Operations Coordination, Capability 3
Emergency Public Information and Warning, Capability 4
Fatality Management, Capability 5
Information Sharing, Capability 6
Medical Countermeasures Dispensing, Capability 8
Medical Material Management and Distribution, Capability 9
Public Health Surveillance and Epidemiological Investigation, Capability 13
Volunteer Management, Capability 15

To reduce reporting burden, CDC may provide the option for states to report data for select performance measures from a sample of counties within each state (as opposed to reporting data from all counties or all local health departments). Further detail on performance measures and reporting requirements for 2012-2013 will be provided to DSHS by the CDC in the future, and DSHS will share this information with Contractors.

The list and requirements for reporting mid-year and annual or other performance measures may change as performance measures are developed, refined, and released by CDC.

Capability	Performance Measure
Community Preparedness	**Median number of community sectors in which local health departments (LHDs) identified key organizations to participate in public health, medical, and/or mental/behavioral health-related emergency preparedness efforts**

	Median number of community sectors that LHDs engaged in using hazards, and vulnerabilities assessment (HVA) data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services
	Proportion of key organizations that LHDs engaged in a significant public health emergency preparedness activity
	Median number of community sectors that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services
Emergency Operations Coordination (EOC)	**Time for pre-identified staff covering activated public health agency incident management lead roles (or equivalent lead roles) to report for immediate duty**
	Production of the approved Incident Action Plan (IAP) before the start of the second operational period
	Time to complete a draft of an After Action Report (AAR) and Improvement Plan (IP)
Emergency Public Information and Warning	**Time to issue a risk communication message for dissemination to the public**
Fatality Management	**Percent of LHDs that have defined fatality management roles and responsibilities of public health in relation to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors)**
Information Sharing	**Proportion of LHDs that can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs)** **<u>HPP-PHEP 6.1:</u> Percent of local partners that reported requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe**

Medical Countermeasure Dispensing and Medical Material Management and Distribution	**<u>Medical Countermeasure Distribution and Dispensing (MCMDD) composite measure</u>**
	MCMDD composite measure score will be calculated annually based on performance data collected from the following preparedness activities:
	• Technical Assistance Review
	• DSNS operational drills
	• Compliance with programmatic standards
	    o Points of dispensing standards data submission
	    o Medical countermeasure distribution standards data submission
	• Full-scale exercises (FSE)
	    o Medical countermeasure distribution
	        ▪ States are required to perform one FSE within the 2011-2016 performance period.
	    o Medical Countermeasure dispensing
	        ▪ Each local CRI jurisdiction is required to perform one FSE within the 2011-2016 performance period.

Public Health	**Proportion of reports of selected reportable diseases received by a**

Surveillance and Epidemiological Investigation	**public health agency within the awardee-required timeframe**
	Proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate timeframe
	Percentage of infectious disease outbreak investigations that generate reports
	Percentage of infectious disease outbreak investigation reports that contain all minimal elements
	Percentage of EI of acute environmental exposures that generate reports
	Percentage of EI reports of acute environmental exposures that contain all minimal elements
Volunteer Management	**Proportion of LHDs that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident** **HPP-PHEP 15.1: Proportion of volunteers deployed to support a public health/medical incident within an appropriate timeframe**

IV. Evidence-based Benchmarks and Pandemic Influenza Plans (PAHPA Benchmarks)

CDC specified a subset of measures and select program requirements as benchmarks as mandated by Section 319C-1 and 319C-2 of the PHS Act as amended by the Pandemic and All Hazards Preparedness Act (PAHPA). To substantially meet a benchmark, Contractors must provide complete and accurate information describing how the benchmark was met. DSHS and the CDC expect Contractors to achieve, maintain, and report on benchmarks throughout the five-year project period. CDC and DSHS reserve the right to modify benchmarks annually as needed and in accordance with CDC goals, objectives, and directives. Contractors shall maintain all documentation that substantiates achievement of benchmarks and make those documents available to DSHS staff as requested during site visits or through other requests.

DSHS has identified the following CDC benchmarks for year one.

1. Adherence to PHEP Reporting Deadlines

Deliverable 1 – Contractors will prepare and submit a PHEP Budget Period 1 mid-year progress report to DSHS using a template provided by DSHS that captures reporting information and data required by CDC. The report is due to DSHS on a date to be determined pending release of the report template from CDC and likely around mid-January 2013. More information on the report is found in the Statement of Work, Section II.

2. <u>Receiving, Staging, Storing, Distributing, and Dispensing Medical Countermeasures:</u> Texas must meet a minimum overall Medical Countermeasure Dispensing and Distribution (MCMDD) composite benchmark of 52 for Budget Period 1. Technical Assistance Review (TAR) performance scores from local health departments contribute to the Texas score.

   Contractors must participate in an annual Technical Assistance Review (TAR). The process includes reviews of documents to support compliance with established medical countermeasure distribution and dispensing standards, target measures, and metrics as described in CDC's MCMDD Composite Guide. The guide is available at DSHS SharePoint portal.

   Contractors will submit data elements for all dispensing sites and modalities that have been identified within the jurisdiction to support a mass prophylaxis scenario to DSHS as part of the TAR process.

   Contractors will conduct a minimum of three (3) different drills (not the same drill performed three times) conducted within each planning/local jurisdiction during year one. The range in scope of available drills provides Contractors with flexibility in meeting the annual drill requirements. The three (3) required drills may be chosen from any of the eight (8) available drills as indicated on the Division of Strategic National Stockpile (DSNS) Extranet website. Drill data and/or Homeland Security Exercise and Evaluation Program (HSEEP) After Action Reports/Improvement Plans for drills (as indicated) must be submitted to DSHS by April 13, 2013.

   Contractors must conduct one (1) full-scale Strategic National Stockpile (SNS) exercise within the five year performance period of 2011-2016 that tests and validates medical supplies distribution and dispensing plans. Results and documentation of medical countermeasure distribution and dispensing full-scale exercise(s) must be developed in accordance with HSEEP standards. Each Contractor will be required to participate in one (1) exercise that demonstrates capabilities for medical countermeasure dispensing operations during the five year performance period. Contractors are encouraged to work with other emergency response agencies or hospital preparedness programs to develop or leverage existing activities to meet the medical countermeasure distribution and dispensing exercise objectives. Details on the scope and format for reporting these exercise requirements will be provided by DSHS through subsequent guidance at a later date.

   Contractors will demonstrate compliance with established medical countermeasure distribution and dispensing standards. Target measures and required data submission will be detailed in supplemental guidance at a later date. Through these activities, contractors will meet the performance measures noted in Section II: Statement of Work Performance Measures of the Program Attachment associated with medical countermeasures.

3. <u>Submission of Pandemic Influenza Plans</u>

Section 319C-1 of the PHS Act, as amended by the Pandemic and All Hazards Preparedness Act (PAHPA), currently requires annual submission of influenza pandemic plans. DSHS will provide further information on the 2012 submission upon release of such information from CDC.

Appendix 1

<u>**Definitions** for the Public Health Capability Model</u>

The **Capability Definition** defines the capability as it applies to state, local, tribal, and territorial public health.

The **Function** describes the critical elements that need to occur to achieve the capability.

The **Performance Measure(s)** section lists the CDC-defined performance measures, if any, associated with a function.

The **Tasks** section describes the steps that need to occur to complete the functions.

The **Resource Elements** section lists resources, including priority items and other considerations, needed to build and maintain the ability to perform the function and its associated tasks. These resource elements are organized as follows:

1) *Planning:* standard operating procedures or emergency operations guidance, including considerations for legal authorities and at-risk populations, for a Contractor's plans for delivering the capability.

2) *Skills and Training:* baseline competencies and skills personnel and teams should possess or have access to when delivering a capability.

3) *Equipment and Technology:* equipment Contractors should have or have access to in jurisdictionally defined quantities sufficient to achieve the capability.

4) **Note**: Certain resource elements have been identified as priority resource elements. Contractors may not require all resource elements to fully achieve all of the functions within a capability, but they must *have* or *have access to* the **priority** resource elements. Remaining resource elements are recommended for consideration by Contractors.

Appendix 2

Appendix 2

The public health preparedness capabilities are listed below in their corresponding domains. These domains are intended to convey the significant dependencies between certain capabilities:

Biosurveillance
- Public Health Laboratory Testing
- Public Health Surveillance/Epidemiological Investigation

Community Resilience
- Community Preparedness
- Community Recovery

Countermeasures and Mitigation
- Medical Countermeasure Dispensing
- Medical Material Management and Distribution
- Non-pharmaceutical Interventions
- Responder Safety and Health

Incident Management
- Emergency Operations Coordination

Information Management
- Emergency Public Information and Warning
- Information Sharing

Surge Management
- Fatality Management
- Mass Care
- Medical Surge
- Volunteer Management